

Developmental Disabilities (DD) Waiver Provider Training

Person-Centered Supports



Wyoming Department of Health
Division of Healthcare Financing
Home and Community-Based Services Section
June 27, 2022



HOME AND
COMMUNITY-
BASED
SERVICES
WYOMING DEPARTMENT OF
HEALTHCARE FINANCING

Good afternoon and welcome to the Developmental Disabilities, or DD, waiver provider training covering person-centered supports. My name is Barb Strasser, I am an Incident Management Specialist with the Provider Support Unit. Thank you for joining us today.



To define and clarify
Person-Centered Supports
within the DD Waivers.

The purpose of today's training is to define and clarify Person-centered support as required by the Comprehensive and Supports waivers, or more commonly referred to as the DD waivers. Person-centered support is outlined throughout the waiver agreement between CMS and the Wyoming Department of Health. Home and Community Based Services, referred to as HCBS, are built around the expectation that all service delivery is specific to the individual receiving the services. Services provided to a participant should meet specific support and supervision needs as identified in the person-centered planning process.

Training Agenda

- Discuss the history of staffing
- Define person-centered supports
- Describe best practices for navigating person centered supports



As we discuss person-centered supports today, it is important for us to demonstrate where we started to understand where we are going. We will discuss the history of staffing and how ratios were a generalization of support needs that lacked the necessary person-centered nature of HCBS. We will also define person-centered supports and identify HCBS expectations and requirements. Finally, this training will provide some best practices for navigating person-centered supports.



A theme throughout all of the Division's provider training is the fact that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives.

DD waiver participants and their families have the right to choose the services, the providers, and how those services are provided. Participants and their plan of care teams work together to describe service delivery needs, wants, and goals within their Individualized plan of care, or IPC, that promote the rights of the participant and align with HCBS requirements and Medicaid Rule. Providers are required to understand and demonstrate the on-going ability to meet the needs of the participant through services, as identified by the plan of care team and documented in the IPC. At any time, if a participant or their team determine the participant's needs are not being met, the participant has the right to choose a different provider to deliver services that meet their needs.

HCBS Authority

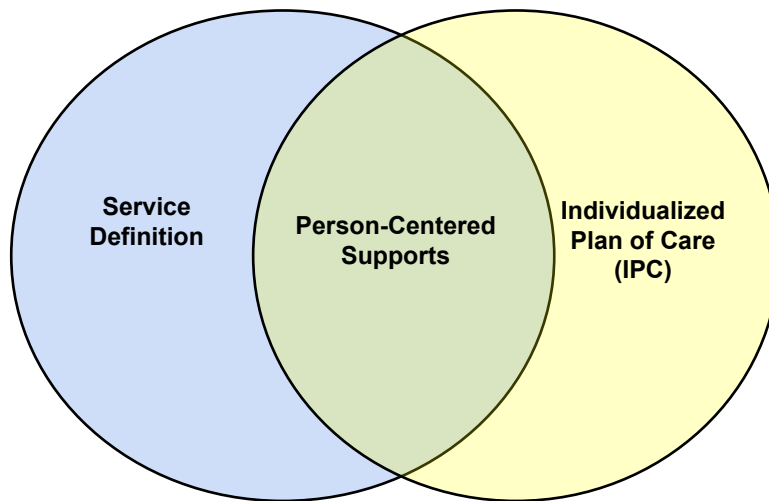
- CMS Approved Waiver Agreements
 - ◆ Available on [HCBS Public notices, Regulatory Documents, and Reports Page](#)
- Wyoming Medicaid Rule Chapter 45
 - ◆ Available on [HCBS Public Notices, Regulatory Documents, and Reports page](#)
 - ◆ Multiple sections including 6, 8, and 13
 - Comprehensive and Supports Waiver Service Index
 - [Available on Service Definitions & Rates page](#)
 - Individualized Plan of Care (IPC)

5

The DD waivers are authorized by CMS. The HCBS program submits an application to CMS to request funding to assist the state in supporting the specific population identified in the application. Through this application the HCBS section and CMS agree on how providers deliver services to support individuals with developmental or intellectual disabilities and acquired brain injuries in their communities and homes.

The contents of the approved waiver agreements are supported by Wyoming Medicaid Rule, specifically Chapter 45 titled “DD Waiver Provider Standards, Certification, and Sanctions.” Chapter 45 covers many different and important pieces of the program, and further defines some program requirements that are not specified within the Waiver agreements. For the purposes of today's training we will discuss Chapter 45, section 6 - Standards for All Providers, section 8 - Documentation Standards, and section 13 - Standards for Home and Community Based Waiver Services. The DD Waiver Service Index provides details about the scope and limitations of each service. The service index also includes information about expectations for support based on the identified level of care of the participant during service provision. The level of care should reflect the required levels of support described in the participant's IPC.

The Intersection



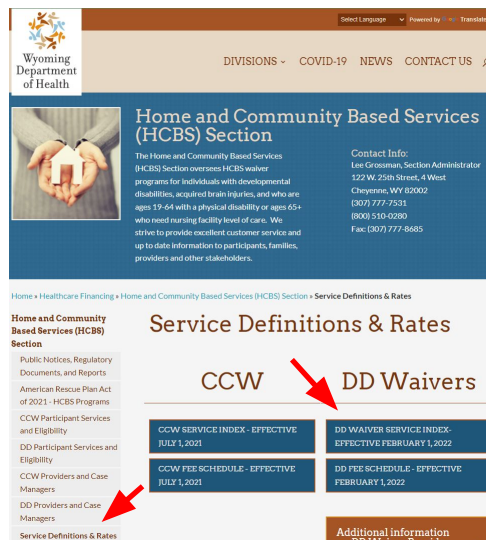
6

Before we move on, we want to clarify that the general requirements for all services are outlined in the service definition; those general services then are tailored to meet the needs identified in a participant's IPC. If you read through the service definitions within the Service Index, there are many references to the level of support that need to be outlined in the participant's IPC. This intersection of service definition and IPC is critical to person-centered supports. Together the IPC and service definition should supply precise information about how services and supports are intended to be provided to the participant.

As we continue to discuss person centered-support it is important to remember that while other individuals may be receiving the same service, the support needs are tailored to each participant's unique needs.

Service Index & Definitions

- One stop shop for:
 - Service Definitions
 - Billing codes
 - Rates
 - Qualifications
 - Scope and Limitations of service
- Available on the [Service Definitions and Rate Page](#)



The DD Waiver Service Index, which houses all of the service definitions, can be found on the [Service Definitions and Rates](#) page. The Service Index is intended to be a one stop shop for information about service definitions, billing codes, and rates. It is a guide for case managers, providers, and participants to use so they can understand the requirements and limitations of each service, as well as qualifications, required documentation, and other expectations that are specific to each service.

Providers who are well versed in the contents of the service definitions will be able to determine their ability to provide the services as outlined by the definition, and also determine the appropriateness of the service in meeting the participant's needs. The service definition should describe the scope and limitations of the service generally, however it is important to remember that the service definition may not include all aspects of the service necessary to meet the needs of the participant. This is where the IPC and the Service index work together to meet a participant's unique needs.

History of Staffing

- Prior to 2014, a common practice for identifying a participant's specific supervision needs was a ratio.
 - ◆ For example: Level 6 participants typically had 1:1 supervision levels listed in their IPCs
- Beginning in 2014 the HCBS Setting Final Settings Rule was implemented and providers submitted transition plans to ensure HCBS standards of person-centered service delivery
 - ◆ The use of ratios was discontinued
- Transition to 1915(c) completed in 2018
 - ◆ Person-centered supervision needs fully implemented

8

Some of you may remember the days of staffing ratios. Prior to 2014 participants were assigned a level of care and based on that level of care, a certain number of staff would be required. The ratios were in the format of staff to participants. Participants with high needs, typically a level 6, would have a one on one direct support staff, or a staffing ratio of 1:1 (one to one) at all times during the service. This allowed providers to identify the number of staff they would need to provide services to a participant at any given time. Participants with fewer support needs might have a staffing ratio of 1 staff per 3 participants or 1:3.

In 2014, CMS implemented the Final Settings Rule. The Final settings rule clarified the requirement of a person-centered planning process. An important element to the planning process is ensuring that participants are able to personally define their desired outcomes. The person-centered service plan is the vehicle that helps the team to reach those outcomes. It makes sense, then, that the plan would need to be tailored to reflect personal preferences and choices, and contribute to the assurance of health and welfare. This process requires plan of care teams to consider the scope of the service as outlined in the service index and how the service could be tailored to meet the specific needs of the individual participant. Standardized staffing ratios would not be applicable when considering a specific individual's needs, as each person has individual needs and preferences for the level of staffing and support they need.

To demonstrate compliance with CMS' Final settings rule, DD waiver providers were required to submit transition plans, identifying how the necessary changes would be

implemented. The Wyoming DD waiver program completed the transition to the Final Settings rule in 2018. Plan of care teams were, and still are, tasked with the incredible work of person-centered planning. We will discuss further what this looks like in practice and how providers are able to determine the best way to provide staffing for participants based on their specific needs within the limits of the service definition.

Person-Centered Support?

- Ratios are easy to read, easy to understand
 - ◆ Limits support available to individual participants in times of need
- Participants have unique diagnoses, conditions, trauma, and personal experiences
- Support needs can change in an instant.
- During services that support multiple participants, all individual needs must be met

10

What do we mean when we say staffing ratios are not person centered? Ratios are easy to understand and can make staffing decisions very simple for a provider. Considering that Waiver participants all have unique needs, wants, and experiences, service providers must recognize that one size does not fit all when it comes to service delivery. Waiver services are intended to support the participant in their home and communities, while fostering healthy social and community integration. *It is very hard to assign a number of staff to support individuals in settings where things are not under the provider's control.*

When developing the person centered plan, the team should discuss any incidents, new concerns, and plans that address the concerns through person-centered support. These ongoing discussions and plans should be translated into the IPC. The needs identified in the IPC should be the information used by the provider to determine how the services will be delivered to meet the needs of the participant, including considerations for staffing.

DD waiver participants have a variety of diagnoses, conditions, trauma, and personal experiences that shape their everyday life and behaviors. The unique individualism of the participant can determine the support levels needed. Let's consider Tom, a waiver participant with a past trauma involving water. Tom's plan of care identifies bodies of water as a trigger for Tom. His Positive Behavior Support Plan, known as a PBSP,

identifies the best way to support Tom is to help him leave the area to get away from the water and talk calmly to him until he is calm. This is the only trigger known to cause behaviors from Tom. As a provider, you are aware of the trigger and plan accordingly for outings. You avoid outings that include swimming pools and lakes. Typically, Tom stays within eyesight without concern and enjoys spending time with one other waiver participant at the same time. Tom, the other waiver participant, and you plan a hike for the next day during Adult Day Service,. While hiking, you come up next to a creek. Tom begins to panic about the water and starts to run, and the other participant turns and runs the opposite direction. Now what? How can you implement Tom's PBSP and support Tom in his moment of need, if you are also looking for the other participant?

This example might be a little simple and very dramatic, but it should help illustrate that a participant's support needs can change at any moment. When services are being provided, the services must meet the needs of *each* participant. In the given scenario, preparation and practice may have helped Tom, the other waiver participant and yourself navigate the outing better.

Wait...
What?



Are we saying that person-centered supports require one staff per participant? No, not at all. The purpose of HCBS is to support individuals in their communities and homes, in the least restrictive manner possible. Participants have the same rights to access their communities and participate in social activities just like you and I.

What we are saying is that it is the provider's responsibility to recognize the support needs of each participant they support and have a plan to meet those needs.

Before You Agree to Support..

Chapter 45, Section 6(b):

Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to:

- (i) Make a determination as to whether the provider is capable of providing services to meet the participant's needs;
- (ii) Consider the safety of all participants who the provider serves in the decision to accept new participants to services or the location for the services; **and...**

11

Chapter 45, Section 6 specifically addresses the responsibilities of a provider when they consider whether or not to support a specific waiver participant. Subsection b reads "Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to make a determination as to whether the provider is capable of providing services to meet the participant's needs, consider the safety of all participants who the provider serves in the decision to accept new participants to services or the location for the services; **and**

Before we get to subsection 3, let's discuss this part of the rule. This section illustrates your responsibility to request and collect enough information to determine whether or not you can meet the participant's needs. This may include, but is not limited to, information about their history, their diagnosis or condition, if they currently have a PBSP, what they want to get out of their services, their interests, and their personal preferences. This may seem like an obvious step for the provider to take when a participant applies for services, but sometimes there can be other pressures to take on a participant that you are not prepared for. It's important to have all the facts and do what is best for you to be able to deliver the highest quality of services to the participant. As a provider you are taking on the incredible responsibility of supporting someone's needs, which is a decision that should never be taken lightly.

Know Your Capacity



(iii) Consider whether the provider has the capacity, commitment, and resources necessary to provide support to the participant served. The provider shall not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs.

14

Section 6, subsection three (iii) requires that you, as a provider, must consider whether your organization has the capacity, the commitment, and the resources necessary to provide support to the participant served.

Let's consider for a second, that your check engine light came on in your car. You don't know what the cause is, but you know waiting to find out could be detrimental. You are also planning a road trip and will need the repair to be completed timely to meet your needs. You contact a service repair garage. The scheduler says they have time available the following day. You arrive at the garage to find that the garage is very busy. When you check in, the scheduler advises that they are overbooked, under staffed, and your service might have to wait a few extra days. The scheduler failed to consider the garage's capacity to serve you, and failed in meeting their commitment to honor the agreement you made in booking your appointment. They did not have the time or resources necessary to meet your repair needs. How would you feel? Frustrated? What would you do? Wait for the garage to meet your needs?

When you are considering whether or not you are able to provide adequate support services to meet a participant's unique needs and goals, set the bar high. You should want to provide THE best service for the people you serve, help them reach their goals, and have fun doing it. If staffing could become an issue, consider that before taking on a new participant's needs. Chapter 45, Section 6 requires that you make this consideration, but we are requesting that you do so with the intent of improving the lives of the people you serve.

This consideration should be thoughtful and complete. Providers should at the very least review the documentation available about the participant. This should include the IPC, other associated documents like PBSPs and protocols, interviews with the participant or legally authorized representative (if applicable), and being up front about any concerns regarding your ability to meet the participant's needs. This applies to all providers, including case managers. Can you be successful in supporting a participant who is working on their behavior in public, looking for a job, or in need of assistance with forms and transportation? Can you support them all at the same time? Being honest about your capacity, commitment, and resources is crucial to the participant in need of support, and is essential to the success of your organization, the participant, and the plan of care team.

Don't Forget

- Chapter 45, Section 8(i)
“A provider staff member shall not bill for the provision of more than one direct service for different participants at the same time.”
- Groups rates should be employed when supporting more than 1 person directly.
- Some IPCs may require both the individual and groups rates
 - ◆ Details about how those units should be utilized should approved by the team and be included in the IPC



13

When agreeing to provide service to a participant, as documented in their IPC and as outlined in the Service index, providers need to consider how their services can translate into compliant business and service delivery methods. As identified in Chapter 45, Section 8(i) provider staff members shall not bill for providing more than one direct service for different participants at the same time. Again, this does not mean that one direct support provider is only capable of supporting a single person at a time.

It is important that you consider not only any overlap of services for compliant billing purposes, but also the participant's needs. Do *both* participants want to receive their services at the same time, from the same provider? What if they don't get along? Participants have the right to make decisions about how their services are delivered, up to and including whether another participant is included in their support services. This should also be documented in the IPC.

If all parties agree that the group support is beneficial for both participants included, some IPCs may require a modification to add group rate units. It is important that the IPC detail how those units should be utilized to ensure the allowable units within the budget are available. Failure to bill a group rate when a single staff supports multiple participants is considered an overpayment and will be referred for recovery to the Medicaid Program Integrity as outlined in Chapter 16, Section 12.

What happens when things change?

14

It's important to remember that things can change for you and the needs of the participant can also change. How you respond will determine how successful you will be in continuing to provide the best services available to the people you support. The next few slides will discuss possible changes that can affect an agreement to provide services and some tips on how to navigate those changes.

Changes for Participants

- Minor changes may include:
 - ◆ Events or activities
 - ◆ Changes to supervision needs
 - ◆ New specialized equipment
- Supporting these changes may require:
 - ◆ Re-routing transportation
 - ◆ Travel to and from special events or activities
 - ◆ New strategies for more supervision in different settings
 - ◆ New/Additional training
- Changes in health, distance, or employment may require more significant changes in service delivery.
- Look for creative solutions within the scope of the service
- Work with the plan of care team as needed
- Unsure? Contact HCBS Section staff

18

A Participant's needs and goals can change over time. Some needs and goal changes can be small, and minor adjustments to service delivery can be made to continue to meet the person-centered support needs of the participant you serve. This might include later or earlier meeting times to accommodate other events or activities, more direct care or supervision during times of stress or stimulation, or using new specialized equipment. These changes might require different transportation options to support changes in times and location, or travel to and from special events or activities. Additional training or adjustments to the supervision the participant receives in different settings may also be needed.

However, sometimes changes for a participant can be significant and may disrupt your usual person-centered support methods. Significant changes may include negative health changes for the participant, distance or location, or employment opportunities, to name a few. So what would you do if the participant you support moves to the next town over? It's only 45 miles one way, or 90 miles round trip, up to 3 days a week - No big deal, right? Maybe not during the summer months, but during the winter Wyoming travel can be a real gamble. Perhaps, the participant specifically relies on your support to help them with grocery shopping, meal prep for the week, and laundry. If you can't make it because of the weather for several days, the participant will be without their much needed services. It's important to be realistic about your abilities to continue to provide quality services that meet the participant's needs.

As we stated before, sometimes adjustments can be made to continue to provide the

quality of services that meet the participant's needs without forcing you to make a decision to discontinue services with the participant. You might have to get creative with changes to service delivery. As we discussed previously, this might include discussing group options for overlapping times with other participants. It's important that you know the scope and limitations of the services you provide to ensure your creative solutions are in compliance with the service requirements. You may need to work with the team to address changes through the IPC. This may include adding units if available or changing the type of service being provided, perhaps a 15 minute unit instead of a daily unit. The HCBS Section wants to encourage providers and plan of care teams to be creative when considering how to meet the changing needs of the participant. If you are not sure if your creative solution is allowable, please contact the HCBS Section staff for more information.

Budget Changes



- Budget increases and decreases can occur
 - ◆ Service to address other participant needs
 - ◆ Participant choice
 - ◆ As a result of ECC
- Supporting participant choice is a provider's obligation
- Work with IPC team when budget changes occur to plan for service delivery through the plan year as needed

20

Depending on the participant's budget, services may require changes. The number of units planned for one service may need to be decreased in order to add other services to a participant's IPC. For example, you notice an upward trend in a participant's challenging behaviors during waiver services, and the plan of care team elects to have Behavioral Support services added to the IPC. The addition of Behavioral Support has to be paid with the participant's existing budget, so the team elects to decrease other services on the participant's IPC. Changes to how the units are distributed between providers can affect your capacity, commitment, and resources as a provider. This change may not only reduce the time you spend with this participant in services, but potentially open up additional time for you to spend in services with another participant.

Participants also have the right to choose to receive services from another provider, because they want to spend time with participants in another provider's program or participate in other community events. Participants have the right to choose their service providers, the services, and how the services are provided. It's possible that the participant you support is interested in spending time with another participant who receives services from a different provider. Supporting changes to accommodate the participant's needs and wishes is a provider's obligation and duty. Some participants, legally authorized representatives, and providers can find making this type of decision difficult which can complicate the change. It's important to remember that every one of

the plan of care team members should have the common goal of improving the participant's quality of life. Even if you are not the chosen waiver service provider, you should want the participant to make choices that improve their happiness and help them achieve success. Interfering with decisions to receive services from another provider or taking any retaliatory action is prohibited and may result in corrective or adverse action.

Other budgetary changes may include the end of supplemental funding awarded through the Extraordinary Care Committee, which we refer to as ECC. The ECC review requests for supplemental or increased funding for participants based on changes in needs or circumstances. This committee will then make the decision to award the funding or deny the request based on the evidence provided and reviewed. Most often, these increases to budgets are only temporary. When supplemental funding ends, units may be decreased back to the annual allowed budget of the participant. Working with the IPC team to understand budget and funding changes can help you plan your service times and methods to cover the service plan year.

Staffing Challenges

- Chapter 45, Section 6(f) requires: “The provider shall, at all times, maintain documentation to demonstrate sufficient staff provide services, supports, and supervision to meet the needs of each participant per the participant’s individualized plan of care.”
- This requires ongoing capacity evaluation and is critical in demonstrating ability to meet participant specific needs.
- Chapter 45, Section 13(g) requires policies and procedures that address back-up and contingency plans
- Providers must comply with labor laws and regulations
- Communicate staffing issues with teams to develop creative short term solutions

22

Not all changes to service delivery are associated with the needs, goals, or preferences of the participant. Providers can experience their own changes that can cause service delivery methods to change. Staffing is a common cause of service delivery changes that many providers have experienced or are experiencing currently. It’s important that we discuss another requirement of Chapter 45. Section 6, subsection f states “The provider shall, at all times, maintain documentation to demonstrate sufficient staff provide services, supports, and supervision to meet the needs of each participant per the participant’s individualized plan of care.” This requires an ongoing capacity and commitment evaluation and is a critical demonstration of your ability to meet the needs of the people you serve.

Person-centered support is rooted in the direct support a participant receives from direct support staff. When staff turnover occurs, it may also change the person-centered support a participant receives. For example, if a female staff member usually supports a female participant, but a male staff member is filling in for the female staff member, how does this change the person-centered support the participant receives? After the unprecedented last two years, staffing shortages have become more common. The HCBS Section understands that some staffing issues and shortages are unavoidable. Let’s face it, at any given time someone may be on vacation or on leave due to death or illness. However, providers are required to have back-up plans, policies, and procedures that address a contingency plan for staffing shortages and essential service continuation. This type of back-up or contingency plan might include having on-call staff to fill in or other service delivery options, like group services. The HCBS Section does not require any specific type of back-up or

contingency plan. Chapter 45 Section 13 requires that providers have written plans for staffing shortages and a contingency plan that assures a continuation of essential services when emergencies occur. The HCBS Section encourages you to be creative in developing and implementing effective and supportive staffing plans that meet the needs of the participants you serve, while continuing to meet the requirements of the service..

Does this mean when you have a staffing shortage you can't meet a participant's needs? Maybe. The most important thing when it comes to staffing shortages that affect service provision is communication. Communication is paramount to finding a solution for short-staffing. Work with the plan of care team when staffing may be a short-term issue. Some participants have natural support that are willing and able to jump in and help with meeting a participant's needs on a short term basis. Like we've said before, being creative may be necessary. The plan of care team can work together to develop a short term plan that will support the participant in receiving the services when available and also through other natural and community resources. These changes, even if temporary, should be documented and updated in the IPC as needed.

It's important for organizations with staff members to remember that staffing must be in compliance with all labor laws and regulations. Overworked staff may experience burnout, causing more staffing shortages. It is important that as an employer, providers have realistic expectations about how person-centered support can be honored when they are short staffed.

What if it doesn't work?

- You must consider the health, safety, and needs of the participant above all others.
- Chapter 45, Section 6(b)(iii):
“...The provider shall not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant’s needs”
- Chapter 45, Section 22 covers all requirements of transitions
- Providers are required to provide a minimum 30 day notice prior to ending services.
- Transitions can be flexible and creative as needed
- Providers must participate as required in transitions

24

Unfortunately, we have to talk about what happens when the participant's needs change or your circumstances change, and you are unable to make the adjustments to support the needs of the participant any longer. We know this is never an easy decision to make. When you establish a relationship with a participant, it's hard to have to admit that you might not be the best provider for them any longer. It's a decision that should not be taken lightly. As a provider, you must consider the health, safety, and needs of the participant above your own. As a reminder Chapter 45, section 6 subsection b tells us that the provider shall not serve a participant if the provider cannot reasonably assure the participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs. We understand that this can be an emotional process for providers, participants, and all the members of their plan of care team. We encourage providers to work with the plan of care team in the most positive way possible to minimize the impact on the participant as they transition to a new provider.

Chapter 45, Section 22 covers the requirements for service transitions, including subsection b which states: “A provider who is terminating services with a participant shall notify the participant and the Division in writing at least thirty (30) calendar days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) calendar day period shall be considered abandonment of services and may result in decertification of the provider.” Transitions can be challenging for everyone, so we would like to remind you that creativity within this rule is allowable and encouraged. Longer notice time periods may be appropriate if short term adjustments remain available, but notices cannot be

provided less than 30 days prior to the last date of service. The most important thing about transitions is ensuring the participant continues to receive the highest quality service and support. The plan of care team is required to meet and the case manager completes a transition checklist to ensure the transition goes as smoothly as possible. Failure to work with the team and assist in the transition is cause for corrective or adverse action as outlined in previously referenced subsection b.

Tips, Tricks, and Best Practices



19

The HCBS section wants providers to succeed, especially through difficult challenges like staffing shortages and transitions. The next several slides will offer some tips, tricks, and best practices for navigating person centered supports, changes, and transitions.

Know Your Limits

- Don't be pressured into making a decision before you have had time to collect & review participant information
- Set your boundaries and stay within them
- Be aware of staff fatigue and burnout
- Be upfront about staffing issues



27

Whether you are considering supporting a new participant or evaluating your ongoing abilities to support a participant through waiver services, one thing you must know are your own limitations. Sometimes providers can feel pressured to make a quick decision when presented with a participant or legally authorized representative's urgent needs. The HCBS Section appreciates the intention to assist and meet participant needs in urgent situations, however making a quick decision without collecting and reviewing the participant's information and evaluating your capacity can have negative outcomes for the participant. It is a provider's responsibility to set criteria about what participant needs you are comfortable and capable of supporting. For example: If you primarily serve adults, it may be necessary to make the decision not to accept children. Similarly, if you provide companion services for a participant with high medical needs, you may decide not to accept any other participants for companion services. The HCBS section encourages you to set your boundaries and stay within them.

Providers who manage staff are responsible for ensuring they have the staff members available to meet the needs of the participants they serve. As an employer, each provider must be aware of the needs of their participants and ensure that staff have the necessary training and skills to meet those needs. As with any employment situation, it is important to also consider the needs of your staff, as well as labor laws and best practices, when forming schedules. The Division recognizes that in this challenging time of workforce shortages, this can be difficult, but encourages providers to be cognizant of how staff fatigue and burnout can affect the services that are being delivered.

If staffing becomes an issue, the best thing you can do is be upfront and communicate the changes. It's important to include the plan of care team in these hardships. The team is made up of individuals who share a common goal to support the participant's needs, wants, goals, and wishes. Together a team should be able to develop a plan that will support the individual using additional resources temporarily, or possibly bringing on additional service providers to assist more long term. Being upfront about staffing issues as soon as possible is one of the easiest ways to get help when necessary, waiting may only lead to further complications and problems.

Be Creative

- Know the participant
 - ◆ Individual needs and preferences
 - ◆ Adjust services to meet individual needs
- Know the service
 - ◆ Scope and Limitations
 - ◆ Daily and 15-minute units
 - ◆ Individual and group rates
- Know the options
 - ◆ Community resources
 - ◆ IPC team resources



29

Person-centered support is all about what the participant needs and wants. Understanding that a participant's needs and wants can change, it's important to remember that service delivery must change to accommodate the person-centered support needs. This requires providers to be creative on a regular basis, but even more so in times of struggle. Providers must be knowledgeable about a number of things, including:

- The participant. The core purpose and intent of person-centered support is the participant. When providers have a good working knowledge about the participant's routines, needs, wants, likes, dislikes, triggers, and preferences the provider is able to make adjustments to service delivery methods and continue to provide person-centered support.
- The service. What are the scope and limitations of the service you are providing? Can you provide it during wake or sleeping hours? Is it a habilitative service that is associated with a goal? Is there a group rate option? Is the service billable in a daily or 15-minute unit? How many hours are necessary to bill a daily rate? Knowing the service limits will help you deliver services in accordance with rule and regulation, but will also assist with identifying additional options within the service.
- The options. What other options are out there? What supports are available within the plan of care team? Does the community offer programs that could help the participant build skills and socialize? Is there an unpaid natural

- support who can assist with support on occasion as a backup plan? Does the participant have additional service providers that can assist with the contingency plan? What resources are available?

HCBS requires person-centered planning, which requires person-centered support and responses. Each participant has unique needs and natural support systems, which should be represented through their person-centered IPC. As a team member, it is important that you provide feedback and participate in person-centered support to the extent possible. The plan of care team must work together to support the participant's unique needs.

Ask for Help

- Providers are part of the participant's plan of care team
 - All members work towards successful person-centered plan and supports.
 - Work within the team to address concerns and ensure contingency of person-centered supports
- The HCBS Section can help!
 - ◆ Benefits and Eligibility Specialists (BES)
 - [Contacts & Important Links](#)
 - ◆ Certification & Credentialing Specialists
 - wdh-hcbs-credentiaing@wyo.gov
 - ◆ Incident Management Specialists (IMS)
 - [Contacts & Important Links](#)

It is important to remember that you are a part of a team for each and every one of the participants you serve. As part of a team you play a vital role in supporting the participant and promoting the success of the person-centered IPC. What does that mean? It means that as a team member, it's important that you support the team in supporting the participant. An IPC is only successful when everyone involved is committed to the success. Sometimes this can require working with the team to address concerns or gaps in service, locating additional resources or options, and having back-up and contingency plans. If you are struggling, don't be afraid to turn to the plan of care team to make a plan and resolve issues through person-centered support and solutions. Person centered planning and support requires all team members to work toward the common goal of the participant.

Where do you turn if the team isn't sure of the options for person-centered support? The HCBS section is familiar with all of the aspects of the program. The Benefits and Eligibility Specialists, we refer to them as BES, are the professionals who assist with person-centered planning through review of IPCs and case management outreach. BES are assigned to participants by their residential county. Case managers often work closely with BES during the plan development and renewal process to submit the person-centered plan created by the team. These specialists have a skill set that supports knowledge of the participant's specific needs and how those needs can translate into the person-centered plan.

The HCBS section also offers the Provider Support Unit as a resource for all providers. The Provider Support Unit, which we refer to as PVS, is made up of two teams that work together to address provider related processes. The two teams are the Certification and Credentialing team, often referred to as just Credentialing, and the Incident Management Team, which we refer to as the IMS team. Appropriate to their titles, the Credentialing team handles applications for initial and renewal certifications with both the DD waiver and the Community Choices Waiver or CCW. The certification and credentialing specialist work together through a common email address wdh-hcbs-credentialing@wyo.gov. Feel free to contact the Credentialing team with questions; if they are unable to provide a direct answer they may be able to offer you information about who can assist you with your inquiry. IMS are assigned to providers based on location, and are responsible for investigating and processing all of the critical incidents and complaints reported to the Section. For information about which IMS is assigned to your county, please visit the [Contacts and Important Links page](#) of the Division's website.



Key Takeaways



- HCBS is person-centered in nature. Person-centered support is the result of implementing a person-centered plan.
- Providers must determine their capacity, commitment, and resources before guaranteeing their ability to provide person-centered support through the waiver.
- Changes can affect the participant's needs and the provider's ability to meet those needs. Work with the team to address concerns.
- Providers should never feel alone in addressing person-centered supports. Working with the plan of care team and the HCBS Section can provide person-centered solutions.

33

As we wrap up, we want to discuss the main points covered in this training.

First, HCBS waivers require a person-centered support approach. The IPC is designed to meet the unique and specific needs of the participant. The support provided through waiver services, in alignment with the Service Index and the IPC, must also be person centered. Person centered services meet the support and supervision needs of the participant in the least restrictive setting, support their rights to access the community, and promote participant safety.

Secondly, providers are required to evaluate their capacity, commitment, and resources before agreeing to serve a participant. Providers need to evaluate initially and on going that they will and continue to meet the participant's needs. If you are unable to guarantee the participant, legally authorized representative, or case manager that you will be able to meet any of the participant's needs, you must not serve that participant. It is up to you, as the provider, to determine your capacity, commitment, and resources so that you are able to be successful in providing the highest quality service to the individuals you serve. Don't just consider if you can meet the needs...set the bar high and be the provider who improves the participant's quality of life through meaningful services.

Next, it's important to remember that participant needs can change and so can your capacity to meet the needs of the participant. Life happens. Staffing shortages have become more common, and providers are no exception. Staff turnover is one of the main reasons for deviation from person-centered supports. The most important thing

is to be upfront about changes that can affect person-centered support. Whether it means that another provider may need to spend time with the participant in your place. Person-centered support requires that the plan of care team work together for the common goal of the participant, which may require tough decisions and realistic evaluations of service delivery capacity. If you are unable to meet the participant's needs, Chapter 45 requires that providers give a 30 day notice and participate in the transition process.

Finally, you are not alone. Many providers have experienced changes that left them short staffed or unable to meet the participant's needs any longer. The HCBS Section encourages providers and plan of care teams to work together and come up with creative solutions that are manageable for the providers, and support the best interests of the participant, such as including natural unpaid support and other community resources. If there is uncertainty regarding creative solutions available to the participant and their team, the HCBS Section is able and willing to assist in identifying potential solutions that may be tailored to meet the participant's needs and complies with HCBS regulations. Don't be afraid to ask for help, you might be surprised at the alternate solutions available.

Questions?
Ask now in the chat!

Contact the HCBS Section:

BES & IMS County Assignments

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

Email: wdh-hcbs-credentialing@wyo.gov

24

Thank you for joining us for today's training. If you have any questions or concerns we would be happy to address them now in the chat. Please feel free to contact the appropriate HCBS Section member for assistance or more information.